MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00695

Reg. Diat. No. .....

1. PLACE OF DEATH: a.a.

County ~~Baltimore~~

City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
4029 Belle Grove Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: aa
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4029 Belle Grove Road
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Andrew Jefferson Allick

3.(b) Social Security Number 214-03-3126

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret A. Allick

6.(c) If alive, give age 56 yrs years

7. Birth date of deceased (mo., day, yr.) November 21, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	10	.....hrs. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Ice Cream Maker

11. Industry or business Good Humor Ice Cream Co.

FATHER
12. Name Henry Allick
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Elizabeth Kahline
15. Birthplace York, Pa.

16. Informant Mr. George Allick
Address 4029 Belle Grove Road, Brooklyn Pk

17. Burial Date thereof Feb. 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18. Funeral director Miller Funeral Home

Address 4510 Liberty Heights Ave.

19. 2/2 19 46 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1946, at 11.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 1945, to January 31 1946 and that I last saw him alive on January 31 1946

Immediate cause of death	DURATION
Pulmonary Edema	
Due to Cardio-Vascular Disease	
Due to Bronchiectasis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Morris W. Steinberg M. D. or other

Address 410 N. Hilton St. Date signed 1 Feb 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 2-16 — 00696

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden Death

Hospital, Institution, or street address where death occurred:
U.S. Naval Academy

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Brownswood (Rural) Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. 2, Box 394, Annapolis, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Roland Anderson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ida Anderson — 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1893

8. AGE:	Years	Months	Days	If less than one day
	52	II	27	____ hrs. ____ min.

9. Birthplace: A.A.Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Matthews Anderson

13. Birthplace: A.A.Co.

MOTHER — 14. Maiden name: Mary Stansburry

15. Birthplace: A.A.Co. Md.

16. Informant: Ida Anderson

Address: R. 2 Box 394, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 25, 1946 (month) (day) (year)

Cemetery or crematory: Broadneck cemetery

Location: Skidmore, Md.

18. Funeral director: J.B. Johnson.

Address: Annapolis, Md.

19. Jan. 25 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated, ~~that I attended deceased from~~ Post mortem Examination

~~and that I last saw him alive on~~ Jany 22 1946

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to	
Coronary Sclerosis	uncertain
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work? ____

23. SIGNATURE: John M. Claffy M.D. Deputy Coroner Ex-officio Examiner
M. D. or other

Address: Annapolis Md. Date signed: 1/24/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown on

FILM No. 100 FEB 7 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00697

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Arnold Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pines on the Severn
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ruby May Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Absalom Anderson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8th 1880 1885

8. AGE: Years	Months	Days	If less than one day
60	1	12	hrs. min.

9. Birthplace Calvert Co Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Samuel Ward
13. Birthplace A A Co Md.

MOTHER
14. Maiden name Lola Sevier
15. Birthplace A A Co Md.

16. Informant Absalom Anderson
Address Pines on the Severn A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 22nd 1946 (month) (day) (year)
Cemetery or crematory Asbury
Location Arnold Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.

19. Jan. 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946, at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 45 1945 to Jan 20 1946 and that I last saw h... alive on Jan 19 1946

Immediate cause of death	DURATION
cerebral hemorrhage	6 days
Due to hypertension w/ cardio-vascular disease	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Bowsuch MD
M. D. or other
Address Annapolis Md. Date signed 1/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00698

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Regional Hosp. Ft. George G. Meade, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Fort George G. Meade, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Post Officers Club, Fort George G. Meade, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: (CIVILIAN)

3. (a) FULL NAME: Eleanor G. Arnold.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 21, 1884

8. AGE: Years: 61 | Months: 2 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: William Jackson

FATHER — 13. Birthplace: Colorado.

MOTHER — 14. Maiden name: —

MOTHER — 15. Birthplace: —

16. Informant: Col. M. Crawford Jr.

Address: Post Officers Club, Fort Geo. G. Meade Md.

17. Removal (Burial, cremation, or removal, Which?) Date thereof 2/5/46 (month) (day) (year)

Cemetery or crematory: Andres Bros. Funeral Home

Location: Sandusky, Ohio.

18. Funeral director: Howard W. Blight Jr.

Address: 4914 Belair Road, Balto - Md.

19. 1 February, 19 46 (Date rec'd by registrar) Frank D. Tolleson

FRANK J. TOLLISON, CAPT., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 January, 19 46, at 2135 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 January, 19 46, to 31 January, 19 46 and that I last saw her alive on 31 January, 19 46

	DURATION
Immediate cause of death: Respiratory failure.	24 hrs.
Due to: Pneumonia, Lobar, Left Lobe	48 hrs.
Due to: Lobar, pneumococcal.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph J. McCarthy, M.D.

M. D. or other

Address: Regional Hospital, Ft. Meade Date signed: 2 Feb 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

00699

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred: 78 Cardwell St - Annapolis Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A. Co.
City or town: Annapolis - Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 78 Cardwell St
(If rural, give LOCATION)
2.(a) If veteran, name war: Yes

3. (a) FULL NAME: Margaret Catherine Baden

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Robert C. Baden (Deceased)
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): December 28, 1852.

8. AGE: Years: 93 | Months: - | Days: 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Prince George County - Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
12. Father's Name: Wilson Turner
13. Father's Birthplace: Prince George Co - Md.
14. Mother's Maiden name: Juanita Turner
15. Mother's Birthplace: Prince George Co - Md
16. Informant: Mrs. Arthur Neal (Daughter) Address: 78 Cardwell St - Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 24th 1946 (month) (day) (year)
Cemetery or crematory: St Pauls Cemetery
Location: Baden Md.
18. Funeral director: Ritchie Brothers
Address: Upper Marlboro Md.
19. Jan 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21, 1946, at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Jan 21 1946 and that I last saw h.er alive on Jan 21 1946

Immediate cause of death: a. Cerebral Hemorrhage b. Arteriosclerotic Heart
Due to: Arteriosclerotic Cardiovascular Disease
Due to: Senescence
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: a. 5 days; Due to: 5 yrs

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 1/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 13 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1616 Mountmor Court
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BARBER - GEORGE WASHINGTON

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ---
7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years: 59 | Months: unknown | Days | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: unknown

FATHER
12. Name: Samuel Barber
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rebecca Lee
15. Birthplace: Maryland

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1946 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Baltimore, Maryland
18. Funeral director: Marbes & Carman
Address: 812 N. Carrollton Ave

19 Jan 24 1946 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 19 46, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 19 45 to Jan. 23 19 46 and that I last saw him alive on January 23 19 46

Immediate cause of death: General Arteriosclerosis — DURATION: Known to us since 12-10-45

Due to:

Due to:

Other conditions: Senile Psychosis — Paranoid Type — Known to us since 12/10/45
(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 1/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

00101

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 5 mos, 27 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 2 yrs, 5 mos, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. -------
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BARNES - CLARA

3.(b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Randolph Barnes
Elkridge, Maryland 6.(c) If alive, give age: unk. years
7. Birth date of deceased (mo., day, yr.): 1873 (?)

8. AGE: Years: 73 ? Months: unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: -------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16-46 (month) (day) (year)
Cemetery or crematory: Mount Calvary
Location: Cala.
18. Funeral director: R E Ellgatt
Address: 1729 N Carlins St

19. 1/14 1946 (Date rec'd by registrar) E Baltimore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 46 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 43, to January 10 19 46
and that I last saw her alive on January 10 19 46

Immediate cause of death: General Arteriosclerosis — DURATION: Known to us since 7/13/43
Due to: ---------
Due to: ---------
Other conditions: ----------
(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op. -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----------
Means of injury ---------- Injured at work? --------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed 1/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00102

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

522 Chesapeake ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 522 Chesapeake ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Crescentia Victoria Basil

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Charles E. Basil

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 28 – 1886

8. AGE:

Years	Months	Days	If less than one day
59		7	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER

12. Name: Balthasar Miller

13. Birthplace: Germany

MOTHER

14. Maiden name: Catherine Steiner

15. Birthplace: Germany

16. Informant: Charles E. Basil

Address: 522 Chesapeke ave Eastport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/4/46 (month) (day) (year)

Cemetery or crematory: St Anne's

Location: annapolis, Md.

18. Funeral director: Ben L. Hopkins

Address: Annapolis. Md.

19. Jan. 7 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 19 46, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45, to Jan 5 19 46 and that I last saw h.e. alive on Jan 4 19 46

	DURATION
Immediate cause of death: Myocarditis & Myocardosis	unknown
Due to: Hypertension	unknown
Due to: Paraplegia (Left)	2 years
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Boul M. D. or other

Address: Annapolis Md Date signed 1-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55) E

CERTIFICATE OF DEATH

00163

Reg. Dist. No.

P

1. PLACE OF DEATH:
County: A. A. Co. Md.
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4404 Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Aydelotte J. Bastian

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19 - 1931

8. AGE:

Years	Months	Days	If less than one day
14	8	27	hrs. min.

9. Birthplace: Brooklyn
(Town, county, and state)

10. Usual occupation:
11. Industry or business: School Girl

FATHER
12. Name: Henry S. Bastian
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Irene L. Brower
15. Birthplace: Baltimore Md.

16. Informant: Henry S. Bastian
Address: 4404 Ritchie Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 19 - 46 (month) (day) (year)
Cemetery or crematory: Western Cem.
Location: Baltimore Md.

18. Funeral director: Flynn & Flynn
Address: 1476 Light St.

19. 1-18 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/16 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to Jan. 16 1946.
and that I last saw h[illegible] alive on 1/15/46 1946

Immediate cause of death	DURATION
Toxemia of pregnancy	
Due to Eclampsia, Eclampsia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Rubin M.D.
M. D. or other
Address: 203 Calapsa Ave. Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3°

1945 - 19 - 46
1939 - 4 - 19
14 - 8 - 27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 11

00104

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 4 mos, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs, 4 mos, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2122 North Howard Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BECKLEY - ROBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Odelphia Beckley, 205 West Lanvale St., Baltimore 6.(c) If alive, give age: unk years

7. Birth date of deceased (mo., day, yr.): 1878 ?

8. AGE: Years: 68 ? Months: unknown Days: If less than one day: --- hrs. ---- min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Pastry Cook

11. Industry or business: ------

FATHER
12. Name: Wilson Beckley
13. Birthplace: unknown

MOTHER
14. Maiden name: Lucy ?
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/28/46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt
Address:

19. Jan 25 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1946 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 1943 to Jan. 20 1946 and that I last saw him alive on January 20 1946

Immediate cause of death: General Arteriosclerosis — DURATION: Known to us since 9/8/43

Due to: ------

Due to:

Other conditions: Senile Psychosis - Simple Deterioration — DURATION: Known to us since 9/8/43
(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. -----

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ---------- Injured at work? -------

23. SIGNATURE: Harold J. Hitchcock M. D. or other
Address: Crownsville, Maryland Date signed 1/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

0C105 20

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: A. A.

County .....

City or town ..... Drurie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... Md. County ..... A. A.

City or town ..... Drurie
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME George Henry Booze

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Sarah Booze

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan 21 1868

8. AGE: Years	Months	Days	If less than one day
77	11	27	.....hrs. .....min.

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual occupation Minister

11. Industry or business

FATHER 12. Name Henry Booze

13. Birthplace Md

MOTHER 14. Maiden name Sarah Miller

15. Birthplace Md.

16. Informant Sarah A. Booze

Address P.O. Lothian, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21 1946 (month) (day) (year)

Cemetery or crematory Moses Cem.

Location Drurie Md

18. Funeral director C. B. Johnson

Address Annapolis Md.

19. 1/19/46 (Date rec'd by registrar) 19..... H. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1946 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1945 to Jan 17 1946 and that I last saw him alive on Nov 6, 1945

Immediate cause of death	DURATION
Myocarditis Chronic	?
Arteriosclerosis Chronic	?
Due to:	
Osteosclerosis	?
Due to:	
Other conditions Gen. Debility	

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F B Vest M. D. or other

Address Lothian Md Date signed 1/19/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 00106

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 Maple Rd
(c) Hospital or institution: Linthicum Heights
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) (6)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Hghts (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Maple Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a)-FULL NAME Patrick James Brennan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1945

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace Pensacola Florida (Town, county, and state)
10. Usual Occupation baby
11. Industry or business

FATHER
12. Name Edward John J. Brennan
13. Birthplace Detroit

MOTHER
14. Maiden Name Betty Ann Kelso
15. Birthplace Wash., D.C.

16 (a) Informant Mrs Brennan
(b) Address 333 Maple Rd Linthicum Hts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) Jan 23, 1946 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1946 at 9:45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchio-pneumonia - Congestion and edema of lungs,
Due to bilateral

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 1-23-46

00107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs, 7 mos, 6 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 8 yrs, 7 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: none given (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: BROCK - WILLIAM

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Polly Brock, 1326 Etting St. Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1880 ?

8. AGE: Years: 66 ? Months: unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Isaac Brock
13. Birthplace: Virginia

MOTHER
14. Maiden name: Jennie Mallory
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/19/46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.

18. Funeral director: Kuper
Address: Crownsville Md

19. 1/19/46 (Date rec'd by registrar) E. Joyce Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 19 46 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 19 37 to January 3 19 46
and that I last saw him alive on January 3 19 46

Immediate cause of death: Epilepsy — DURATION: Known to us since 5/27/37
Due to: ---
Due to: ---
Other conditions: Epilepsy with Psychosis
(Include pregnancy within 3 months of death)

Major findings of operations: --- Date of op. ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE: Hart J. Hinkemeyer M. D. or other
Address: Crownsville, Maryland Date signed 1/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

00168

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1927
Hospital, institution, or street address where death occurred:
84 Franklin St. Annapolis Md.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 84 Franklin St. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Isaac Brown Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Married

6.(b) Name of husband or wife: Lottie Brown
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): May 8, 1884

8. AGE: Years	Months	Days	If less than one day
61	8		...hrs. ...min.

9. Birthplace: Millersville A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: None

FATHER
12. Name: Isaac Brown
13. Birthplace: Millersville Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Isaac Brown Jr.
Address: 1114 Riggs Ave. Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/46 (month) (day) (year)
Cemetery or crematory: Cross Roads Cemetery
Location: Waterbury Md. A. A. Co.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25, 1946, at 10:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24, 1946, to Jan 25, 1946, and that I last saw him alive on Jan 25, 1946

Immediate cause of death	DURATION
Cerebral Hemmorhage	2 Days.
Due to: Arterial Hypertension	1 Year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed 1/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

00169

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 13 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 8th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: John Burley

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): July 4, 1871

8. AGE:

Years	Months	Days	If less than one day
74	6	23	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Sam Burley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sally Burley
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 29, 1946 (month) (day) (year)
Cemetery or crematory: Bacon Chapel
Location: Anne Arundel County

18. Funeral director: W. R. Selby
Address: Laurel, Maryland

19. 1/30/46 (Date rec'd by registrar) Clara Hasley Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27, 19 46, at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14, 19 45, to Jan. 27, 19 46, and that I last saw him alive on January 26, 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 12/14/45
Due to: ---	
Due to: ---	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 12/14/45

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert A. Winebrenner M. D. or other
Address: Crownsville, Maryland Date signed: 1/27/46

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 00110 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Bradbury Buxton — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife: Annette E. Buxton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9th 1879

8. AGE: Years	Months	Days	If less than one day
66	8	4	..... hrs. ..... min.

9. Birthplace: Franklin New Hampshire (Town, county, and state)
10. Usual occupation: Ret. C.P.O.
11. Industry or business

FATHER
12. Name: Anson Buxton
13. Birthplace: Vermont

MOTHER
14. Maiden name: Adella Clough
15. Birthplace: Vermont

16. Informant: Mrs Annette E. Buxton
Address: Arnold Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 16th 1946 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Baltimore Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Jan. 16 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1946; at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1, 1945, to Jan. 13 1946
and that I last saw h... alive on January 13. 1946

	DURATION
Immediate cause of death: Acute dilatation of the Heart	Hours
Due to: Arteriosclerotic Cardio-Vascular disease	5 yrs.
Due to:	
Other conditions: Internal Hemmorhage. Cause: Unknown.	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Gilbert L. Anderson M.D.
Address: Annapolis, Md. M. D. or other
Date signed: Jan. 13. 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06113

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: St Margarets

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Pearl May Cantler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 7th 1945

8. AGE:

Years	Months	Days	If less than one day
	1	23	..... hrs. ..... min.

9. Birthplace: A A Co Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Louis David Cantler

13. Birthplace: A A Co Md.

MOTHER 14. Maiden name: Elizabeth Richis

15. Birthplace: A A Co Md.

16. Informant: Mrs Irvin Patterson

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 1st 1946 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md.

18. Funeral director: John M Taylor Son

Address: Annapolis Md.

19. Feb. 1st 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 30, 1946, at 1-10 P M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination ~~and that I last saw him alive on~~ Jany. 30 1946

Immediate cause of death	DURATION
Broncho-Pneumonia	4 days
Due to: Acute Coryza	1 month
Due to: Marasmus	3 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A Caffey Deputy Medical Examiner

M. D. ~~or other~~

Address: Annapolis Md. Date signed 2/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00114

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Defense Highway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William E Charlton Jr

3.(b) Social Security Number: 227-12-1822

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21st 1921

8. AGE:

Years	Months	Days	If less than one day
24	5	10	..... hrs. ..... min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: Motion Picture Operator
11. Industry or business: Circle Theater
12. FATHER — Name: William E. Charlton Sr.
13. FATHER — Birthplace: Va
14. MOTHER — Maiden name: Elizabeth Forney
15. MOTHER — Birthplace: North Carolina
16. Informant: Wm E. Charlton Sr.
Address: Defense Highway A A Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 2 1946 (month) (day) (year)
Cemetery or crematory: St Mary's Cemetery
Location: Annapolis Md.
18. Funeral director: John M Taylor & Son
Address: Annapolis Md.
19. Jan. 2 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 1 1946 at 2.15 P M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19.. to 19.. ~~and that I last saw him alive on~~ Jany 1 1946
Post Mortem & Examination

	DURATION
Immediate cause of death: Ruptured Bladder	
Internal Injuries	
~~Due to~~ Fracture of Both Hips and Pelvis	
~~Due to~~ Accident Run over by rear wheels of Bus	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Jany 1 1946
Where did injury occur? Parole (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Defense Highway
Means of injury: Cr. Ac. Run over by Bus Injured at work? No

23. SIGNATURE: John M Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 1/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

00115

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Riva, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Tudor Hall

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Tudor Hall
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Nathan Herbert Childs

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 8, 1874

8. AGE:

Years	Months	Days	If less than one day
71	5	20	____ hrs. ____ min.

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER
12. Name: J. Nathan Childs
13. Birthplace: a. a. co., Md.

MOTHER
14. Maiden name: Margaret H. Hardesty
15. Birthplace: a. a. Co., Md.

16. Informant: Eugene P. Childs
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany. 30, 1946 (month) (day) (year)

Cemetery or crematory: All Hallows Cemetery

Location: Davidsonville, Md.

18. Funeral director: John M. Taylor and Son

Address: Annapolis, Maryland

19. Jan. 30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28, 1946 19 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-7-46 19 to 1-28-46 19

and that I last saw h alive on 1-28-46 19

Immediate cause of death	DURATION
Acute Dilatation of	Few hours
Due to the Heart	Few hours
Due to Arteriosclerotic Cardio-Vascular	3 yrs.
Other conditions Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other

Address: Annapolis, Md. Date signed 1-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

00116

27

1. PLACE OF DEATH

County Anne Arundel

Registration Dist. No.

Village or City Bacons Chapel near Laurel No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Lucy Colbert

If U. S. Veteran, specify WAR

(a) Residence: No. Bacons Chapel near Laurel Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Colored	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Halton Colbert

6. DATE OF BIRTH (month, day, and year) March 2 1865

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. House wife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md.

FATHER

13. NAME Samson Powell

14. BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md

MOTHER

15. MAIDEN NAME Margaret Powell

16. BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md

17. INFORMANT Lola Watkins (Address) Laurel Laurel R. F. D.

18. BURIAL, CREATION, OR REMOVAL Place Bacons Chapel Date Jan 12, 1946

19. UNDERTAKER Richley Shelby (Address) 401 Washington Laurel Md

20. FILED 1-12, 1946 Clara Haslup Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 1 (Month) 8 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 12-10, 1945, to 1-8, 1946.

I last saw her alive on 1-8, 1946; death is said to have occurred on the date stated above, at 2.20 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Myocardial Failure	2 wk
Arteriosclerosis	10 yr

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible] M. D.

(Address)

V. S. No. 1

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00111

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 German
(If rural, give LOCATION)
2.(a) If veteran, name war: World

3. (a) FULL NAME: James Roy Crawford, Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6.(b) Name of husband or wife: Mary R. Crawford
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 20 1898

8. AGE: Years: 47 Months: 7 Days: 22 If less than one day: hrs. min.

9. Birthplace: Annapolis, Md (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: Paper
12. Name of FATHER: Franklin E. Crawford
13. Birthplace of FATHER: Maryland
14. Maiden name of MOTHER: Annie E. King
15. Birthplace of MOTHER: Maryland
16. Informant: Mary R. Crawford
Address: 13 Germon St Annapolis, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3/46 (month) (day) (year)
Cemetery or crematory: Cedar Bluffs
Location: Annapolis Md
18. Funeral director: B. E. Hopkins
Address: Annapolis. Md
19. Feb. 1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31. 1946, at 4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1. 1946 to Jan 31. 1946
and that I last saw h... alive on Jan 31. 1946

Immediate cause of death	DURATION
Acute dilatation	3 minutes
Due to: Fatty Heart	
Due to:	
Other conditions: Arteriosclerotic Cardio Vascular disease	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert G. Anderson M.D. M. D. or other
Address: Annapolis Md Date signed: 1/31/46

VS A15 *

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

00112 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn R F D. Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All her life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn R F D. Md (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Beulah Cromwell
3.(b) Social Security Number none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Sedwick T. Cromwell
6.(c) If alive, give age: 83 years
7. Birth date of deceased (mo., day, yr.): Nov 18, 1870
8. AGE: Years 75 Months 1 Days 18 If less than one day ... hrs. ... min.
9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home.
FATHER 12. Name: Rufus B. Phelps
13. Birthplace: A. A. Co. Md.
MOTHER 14. Maiden name: Addie Warfield.
15. Birthplace: A. A. Co. Md
16. Informant: R. Chester Cromwell
Address: Brooklyn. R F D. Md.
17. Burial. (Burial, cremation, or removal, Which?) Date thereof: Jan. 9, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: near Brooklyn. A. A. Co.
18. Funeral director: Tinker.
Address: Balto. Md
19. 1-7 1946 (Date rec'd by registrar) A W Hedrick, ask, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1946, at 8:35 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1944, to Jan 6 1946
and that I last saw her alive on Jan 5 1946

	DURATION
Immediate cause of death: Hemorrhage in the Brain	4 days
Due to: Cardio - Vascular Disease	2 years
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations: None
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James S. Billingslea, M.D. M. D. or other
Address: Glen Burnie. Md Date signed: Jan. 6. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

00117

Reg. Dist. No. 19-27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort Meade Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME William Donovan.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Grace Donovan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	1	..... hrs. ..... min.

9. Birthplace: Ellicott City, Md. (Town, county, and state)
10. Usual occupation: Clerical
11. Industry or business
FATHER 12. Name: Alex J. Donovan
FATHER 13. Birthplace
MOTHER 14. Maiden name: Mary Naughton
MOTHER 15. Birthplace: Ireland
16. Informant: Alex J. Donovan
Address: Marriottsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 10 1946 (month) (day) (year)
Cemetery or crematory: St. Alphonsus Cem.
Location: Woodstock, Md.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. Jan. 9 1946 (Date rec'd by registrar) John B. Laughran (Per B. C. E.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 7 1946 at ..... M
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination
~~and that I last saw him alive on~~ Jany. 7 1946

Immediate cause of death	DURATION
Due to: Cerebral Hemorrhage	Sudden
Due to: Arteriosclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: Jany. 7, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00118

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: A A
City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State: Md. County: A A
City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME W. Frank Dorsey

3. (b) Social Security Number

4. Sex: M
5. Color or race: C
6.(a) Single, married, widowed, or divorced: M
6.(b) Name of husband or wife: Daisy Dorsey
6.(c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): Oct 1 1888

8. AGE: Years 57 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: James Dorsey
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Davis
15. Birthplace: Md
16. Informant: Sherman Dorsey
Address: Owings Md
17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Jan 5 1946 (month) (day) (year)
Cemetery or crematory: Friendship Cem
Location: Friendship Md
18. Funeral director: G. A. Hayden & Son
Address: Galesville Md
19. 1/4 1946 (Date rec'd by registrar)
H. R. Clayton, Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/3 1946, at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to 1/3 1946
and that I last saw him alive on 1/3 1946

Immediate cause of death: Acute myocarditis | DURATION: 1 mo

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: H. M. Ward, M. D. or other
Address: Owings Md
Date signed: 1/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

CERTIFICATE OF DEATH

00119

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 8 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 3 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #1 (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: FAX - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Pearl Fax, Aberdeen, Md.
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): July 18, 1906

8. AGE:

Years	Months	Days	If less than one day
39	6	3	---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: Isaac Fax
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Cotton
15. Birthplace: Maryland

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Harford County
18. Funeral director: Henry Tarring and Sons
Address: Aberdeen, Maryland

19. 1/22 19 46 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 19 46 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 45 to Jan. 21 19 46 and that I last saw him alive on January 21 19 46

Immediate cause of death: General Paresis — DURATION: Known to us since 10/13/45
Due to: ----
Due to: ----
Other conditions: ----
(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.: ----
Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: ---- Injured at work? ----

23. SIGNATURE: Herbert V. Winebrook M. D. or other
Address: Crownsville, Maryland Date signed: 1/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 3-45

00120 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH: An. Ar. Co;
County ..... Sal. hey R.F.d
City or town ..... Glenburnie Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... Md ..... County .....
City or town ..... Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... Sahley
(If rural, give LOCATION)
2.(a) If veteran, name war ..... No

3. (a) FULL NAME Fredrick W Glass

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Spring Ill.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Lena Glass
Address Sally R F 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19-46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Arundel County

18. Funeral director Joseph Karoukas Jun.
Address 604 Wash. Blvd

19. 1-18 19 46 A W Hobson adk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 19 46 at 5 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 5 1946 to Jan 16 1946 and that I last saw him alive on Jan 9 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Lobar.	
Due to:	
Other conditions: Hypostatic Congestion	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Samuel Carlson M.D.
M. D. or other
Address 203 Belaplace Ave. Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Johnson

00121

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Lusby Crossing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Lusby Crossing

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Lusby Crossing

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jeremiah Hall Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elzena Hall

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1862

8. AGE: Years	Months	Days	If less than one day
83	9		hrs. min.

9. Birthplace: Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Thomas Hall

13. Birthplace: Prince George Co.

MOTHER — 14. Maiden name: Nellie Hebron

15. Birthplace: Prince George Co.

16. Informant: John W. Hall

Address: Lusby Crossing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Tabor Mt. Tabor

Location: Chesterfield, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md.

19. Jan. 15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13, 1946 at 5:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1944, to Jan 13 1946 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac Failure	1 yr.
Due to: Mitral Insufficiency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L.O. Johnson M. D. or other

Address: Lusby Md. Date signed: 1-15-46

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

00122

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, Institution, or street address where death occurred: Emergency Hospt. Annapolis Md.
How long in hospital or Institution? about 3 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 College Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Lee Roy Haste

3.(b) Social Security Number: 214-05-2257

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Annie Haste
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 27, 1890

8. AGE: Years	Months	Days	If less than one day
55			____ hrs. ____ min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None

FATHER
12. Name: Horace Haste
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Mary Harris
15. Birthplace: A. A. Co. Md.

16. Informant: Mrs Annie Haste
Address: 3 College Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/46 (month) (day) (year)
Cemetery or crematory: Brewhill Cemetery
Location: West St extd. Annapolis Md.

16. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 18 1946 (Date rec'd by registrar) Registrar B.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 14 1946, at 12 10 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~What I attended deceased from~~ Postmortem Examination Jany 14 1946 ~~and that I last saw him alive on~~

Immediate cause of death	DURATION
Fracture of neck	1 hr. 50 min.
~~Doctor~~ Fracture of Skull	1 hr. 50 min.
Due to Automobile accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1/13/46
Where did injury occur? Annapolis A. A. Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Ext. Hwy George St. & College Ave.
Means of injury: Automobile collision Injured at work? No

23. SIGNATURE: John N. Flatty M.D. County Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed 1/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06123

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel Co
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A.Co.
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Robt. Haughliter Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	wh.	M

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1873

8. AGE: Years 72 | Months 11 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation monot. pe operator (retired)

11. Industry or business

FATHER 12. Name Robt. P. Haughliter
13. Birthplace Philadelphia, Pa.

MOTHER 14. Maiden name Laura Fleckenstine
15. Birthplace Philadelphia Pa

16. Informant Dorothy V. Haughliter
Address Washington D.C.

17. Removal Date thereof Jan 29 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Washington D.C.
Location

18. Funeral director T. F. Costello
Address 1722 N. Capitol St.

19. Jan 29 1946 Wm. D. Brooks
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1946 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Jan 29 1946 and that I last saw h.. alive on Jan 29 1946

Immediate cause of death	DURATION
Coronary occlusion	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Brooks M.D.
M. D. or other
Address Amos Garret Blvd Date signed 1-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00124

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A A Co.
City or town Annapolis Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County A. A. Co.
City or town Friendship
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frances Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years 3 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Friendship Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Wilbert Hawkins
13. Birthplace md.

MOTHER 14. Maiden name Edna Creek
15. Birthplace md.

16. Informant Edna Hawkins
Address Friendship md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/46 (month) (day) (year)
Cemetery or crematory Cemetery
Location Halls Creek.

18. Funeral director Wm H. Hutchins
Address Owings md.

19. Jan 2 1946 (Date rec'd by registrar) Grace L. Hutchins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2 1946, at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12 1945, to 1-2 1946
and that I last saw h.. liv.. alive on Dcember 31 1945

Immediate cause of death	DURATION
Sinus 3rd degree burns	
over about 1/3 body surface	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson M.D.
M. D. or other
Address Lothian, md. Date signed 1-1-45

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

00125

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Hackley (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Hackley Md (If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John C Henson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colour	widow

6.(b) Name of husband or wife Sarah Henson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1876

8. AGE: Years	Months	Days	If less than one day
69	5		hrs. min.

9. Birthplace So. River, A. A. Co. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Wm. Henson
13. Birthplace Md

MOTHER
14. Maiden name Mariah Hill
15. Birthplace Md.

16. Informant Elizabeth Bias
Address R. 1. Box 104 Annap.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6 1946 (month) (day) (year)
Cemetery or crematory Lowes Chapel
Location A. A. Co.
18. Funeral director J. B. Johnson
Address Jonestown
19. Jan 6 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1946, at 6.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1945, to Jan 2 1946
and that I last saw h alive on Jan 2 1946

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. W. Johnson M. D. or other
Address 48 Hartland Ave Date signed 1/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Civilian

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00126 27

Reg. Diat. No.

1. PLACE OF DEATH:

County Anne Arundel County

City or town Fort Geo. G. Meade Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Regional Hospital Fort George G. Meade Md

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Fort George G. Meade Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 199 Civilian Barracks

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bert Herrick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Grace Herrick

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) October 19 1873

8. AGE: Years 72 | Months 3 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Eaton N. Y. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Augustus Herrick

13. Birthplace Unknown.

MOTHER 14. Maiden name Josephine —

15. Birthplace Eaton, N.Y.

16. Informant Mrs. Grace Herrick

Address Church St. Savona, New York.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1 29 46 (month) (day) (year)

Cemetery or crematory John Stover Funeral Home

Location Corning, New York

18. Funeral director Howard M. Blight Jr.

Address 4914 Belair Road, Balto-Md.

19. 28 January 1946 (Date rec'd by registrar) Frank J. Tollison (FRANK J. TOLLISON, CAPT., Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 January 19 46, at 6:50 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 25 Jan. 19 46, to 27 Jan. 19 46

and that I last saw h.im alive on 27 Jan. 19 46

	DURATION
Immediate cause of death Myocardial infarction	5 days
Due to Coronary artery occlusion	5 days
Due to Coronary arteriosclerosis ?	
Other conditions Rt. lower lobe pneumonia. (Include pregnancy within 3 months of death)	5 days

Major findings of operation (none) Date of op.

Autopsy results Anterior myocardial infarction.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Long M. D.

Address Reg. Hosp. Ft. G. G. Meade Md. M. D. or other

Date signed 28 Jan. 46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00127

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: Crownsville.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Hebster Hess.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Divorced.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28 - 1858

8. AGE:

Years	Months	Days	If less than one day
87	6	3	hrs. min.

9. Birthplace: Westminster, Maryland (Town, county, and state)
10. Usual occupation: cement Mason
11. Industry or business
12. FATHER — Name: Joseph Hess
13. FATHER — Birthplace: Maryland.
14. MOTHER — Maiden name: ?
15. MOTHER — Birthplace: ?
16. Informant: Mrs Rose Hess (Married Daughter)
Address: Crownsville.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28/46 (month) (day) (year)
Cemetery or crematory: St. Stephens
Location: Millersville Md.
18. Funeral director: B. L. Hopkins
Address: Annapolis Md.
19. 1/28. 46 E. Jones Love
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1946, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1946 to January 25 1946
and that I last saw h.e.r. alive on 1/26/46 19

Immediate cause of death	DURATION
Heart failure	2 days.
Due to: General debility	
Due to: debility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leland H. Pardee M.D.
M. D. or other
Address: Glen Burnie Md. Date signed 1/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00128

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Defence Highway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Defence Highway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John L. Hoagland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Maude Hoagland
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 21, 1863

8. AGE: Years	Months	Days	If less than one day
84	11	6	hrs. min.

9. Birthplace: Penn.
(Town, county, and state)
10. Usual occupation: Watch Maker Ret.
11. Industry or business:
FATHER 12. Name: John Hoagland
13. Birthplace: Penn
MOTHER 14. Maiden name:
15. Birthplace
16. Informant: John J. Hoagland
Address: 2419 18th St N.W. Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 31st 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Washington D.C.
18. Funeral director: John H. Taylor Son
Address: Annapolis Md.
19. Jan. 30 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 27 1946 at about 7 A M
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination
Jany. 27 1946

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to: Chronic Myocarditis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Anne Arundel Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 1/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

00129

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 2 Martin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 Martin St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Anna Rebecca Jacobs

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John W. Jacobs
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1857

8. AGE: Years	Months	Days	If less than one day
88	3	18	hrs. min.

9. Birthplace: St. Margaret, A.A.Co., Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: John Boone
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza A. Bamford
15. Birthplace: Maryland

16. Informant: Mrs. E. C. Burt
Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 11, 1946 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Annapolis, Md.

18. Funeral director: John W. Taylor Ed Son
Address: Annapolis, Md.

19. Jan. 11 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1946, at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Jan 8 1946 and that I last saw her alive on Jan 8 1946

Immediate cause of death	DURATION
Myocardial & Myocardial Insufficiency	10 min
Due to: Arterio Sclerosis	unknown
Due to:	
Other conditions: Uremia	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other
Address: Annapolis, Md. Date signed: 1/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00130

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, Institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution? entered January 23, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 63 Spa. Rd. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Rev. Eva Savoy Jefferson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Coral Jefferson
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 23, 1894

8. AGE: Years	Months	Days	If less than one day
51	3		hrs. min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Minestery
11. Industry or business: Minestery
FATHER 12. Name: Joshua Savoy
FATHER 13. Birthplace: Annapolis Md. A. A. Co.
MOTHER 14. Maiden name: Molly Scott
MOTHER 15. Birthplace: Prince George Co.
16. Informant: Mrs Helen Jones
Address: 59 Spa Rd. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/46 (month) (day) (year)
Cemetery or crematory: St. Annes Cemetery
Location: Northwest St. Extd. Annapolis Md.
18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.
19. Jan 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1946, at 9.57 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1946 to Jan 25 1946 and that I last saw h.. alive on Jan 24 1946.

Immediate cause of death	DURATION
Carcinoma of Stomach	3
Due to Acute Gastric Hemorrhage	2 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Klaware, Md. M. D. or other
Address: 31 Smith gate W Date signed 1/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00131

Reg. Diat. No. 26

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 341 Robert Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: JOHNSON - MAGGIE

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Robert Johnson, 341 Robert St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 58 Months: unknown Days: If less than one day: ---hrs. ---min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER
12. Name: Lucius Tomlin
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Jessup
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 3, 1946 (month) (day) (year)
Cemetery or crematory: Lancaster County (Family Lot)
Location: Virginia

18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Avenue, Baltimore, Md.

19. 2-2-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1946, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 6, 1945, to Jan. 30, 1946 and that I last saw her alive on January 30, 1946

	DURATION
Immediate cause of death: General Paresis	Known to us since 11/6/45
Due to: -------	
Due to: -------	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: --------- Date of op.: ------

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---------
Means of injury: --------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 1/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

00132

★ Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs, 11 mos, 1 day
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 8 yrs, 11 mos, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2000 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3. (a) FULL NAME: JORDAN - ANNA

3. (b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1889 ?

8. AGE: Years: 57 ? Months: unknown Days: ---- If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: ------

FATHER
12. Name: Moses Morris
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ellen Sawyer
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-1-46 (month) (day) (year)
Cemetery or crematory: Mt Colony
Location:

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave.

19. Feb 1 1946 E. F. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1946, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 1937, to Jan. 28 1946 and that I last saw her alive on January 28 1946

Immediate cause of death	DURATION
Chronic Myocarditis with	Known to us since
General Arteriosclerosis	2/27/37
Due to: -------	
Due to: -------	
Other conditions: Involutional Psychosis	Known to us since
(Include pregnancy within 3 months of death)	2/27/37

Major findings of operations: -------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: -----
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Fred J. Sinderbrand M. D. or other
Address: Crownsville, Maryland Date signed: 1/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

00133

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Waugh Chapel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills, R. 3. D.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Waugh Chapel Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John M. Kahring

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Dina Kahring Nee Peters

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 29 1856

8. AGE:

Years	Months	Days	If less than one day
89	4	10	hrs. min.

9. Birthplace: Sheboygan Wis (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

MOTHER FATHER

12. Name: August Kahring

13. Birthplace: Germany

14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: B. B. Kahring

Address: Gambrills, Md R. 3. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14. 1946 (month) (day) (year)

Cemetery or crematory: Waugh Chapel Ch. Cemetery

Location: Waugh Chapel A. A. Co. Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Jan 10 1946 (Date rec'd by registrar) Mildred Lapp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9 1946, at 12 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1942 to Jan 9. 1946 and that I last saw him alive on Dec 18 1945

Immediate cause of death	DURATION
Chronic Valvular heart disease	3 yrs.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. Hagan, M.D. M. D. or other

Address: Pleasant Hill Md Date signed Jan 9 1946

Evidence for change of age and birthdate of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00134 21

Reg. Dist. No.

FILM No. I 04 JUN 11 1946

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Clearwater Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Clearwater Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HYPOLIT - KARWOWSKI

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jozefa
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): aug 12 1864

8. AGE: Years	Months	Days	If less than one day
81 4			hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Self

FATHER
12. Name: Maciej Karwoski
13. Birthplace: Poland

MOTHER
14. Maiden name: Jozefa Cwalina
15. Birthplace: Poland

16. Informant: Anthony Karwoski
Address: Clearwater Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15-46 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: A. A. Co.

18. Funeral director: Wm. S. Fialkowski
Address: 2007 Eastern Ave

19. 1-14 1946 A W Hefnick Clk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11th 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.. to Jan 11th 1946
and that I last saw him alive on Jan 10th 1946

Immediate cause of death	DURATION
Coronary Thrombosis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John J Alexander M. D. or other
Address: John Bunner M. Date signed: 1/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

00135

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel -

City or town: new Glen Burnie -

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Anne Arundel

City or town: new Glen Burnie. no

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stevenson Road off Quarterfield Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: Nil

3. (a) FULL NAME: James Edwin Kellenberger.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	white.	Married

6.(b) Name of husband or wife: Mary Elizabeth Kellenberger

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Feb 4, 1862 -

8. AGE: Years	Months	Days	If less than one day
83	11	18	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. - (Town, county, and state)

10. Usual occupation: Steam Fitter - (Retired)

11. Industry or business: Steam Fitting.

FATHER — 12. Name: James Kellenberger.

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Mary Reisters.

MOTHER — 15. Birthplace: Maryland -

16. Informant: Frank Kellenberger.

Address: Glen Burnie - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: JAN 21 - 1946 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Livingston

Address: Glen Burnie, Md.

19. Jan. 18 1946 (Date rec'd by registrar) Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17 1946 at 7:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1946, to Jan 17 1946 and that I last saw h— alive on Jan 17 1946

Immediate cause of death	DURATION
Cardio - Vascular Disease.	3 years.
Due to: Senil.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James S. Bellenghia M. D.

M. D. or other

Address: Glen Burnie Md. Date signed: Jan 17, 1946.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00136

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Herald Harbor, Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1638 Ashburton St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Charles Kinstendorff. **3.(b) Social Security Number:** 218-10-5893

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Iris Kinstendorff
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 8. 1880

8. AGE:

Years	Months	Days	If less than one day
65	5	24	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Retired Time Keeper
11. Industry or business: Maryland Standard Sanitary Mfg Co.

FATHER
12. Name: Charles Kinstendorff
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Alice Huff
15. Birthplace: Carroll County, Maryland.

16. Informant: Mrs. Iris Ward
Address: Herald Harbor, Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4, 1946 (month) (day) (year)
Cemetery or crematory: Nichols Memorial Gardens
Location: Odenton, Md.
18. Funeral director: Thomas W. Pinglatou
Address: Glen Burnie Md

19. Jan 4 1946 (Date rec'd by registrar) Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1946, at 3 30 P. M.
21. I CERTIFY that death occurred on the date above stated. ~~that I attended deceased from~~ Post mortem examination to 19 ; and that I last saw ~~him~~ alive on January 1 1946

Immediate cause of death: Acute Dilatation of Heart — DURATION: —
Due to: Chronic Myocarditis — DURATION: 2 years
Due to: — DURATION: —
Other conditions — DURATION: —
(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John M. Latrobe M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed 1/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00137

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: North Magothy Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. North Magothy Beach
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Archie Krantz

3.(b) Social Security Number: UNKNOWN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): not known 1872

8. AGE: Years: about 73 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: watchman

11. Industry or business: odd jobs

FATHER
12. Name: not known
13. Birthplace:

MOTHER
14. Maiden name: not known
15. Birthplace:

16. Informant: George Bohn, Sgt. County Police
Address: Sub-Sta. "A", A.A. Co., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3, 1946 (month) (day) (year)
Cemetery or crematory: Marley Neck Church yard.
Location: Marley Neck Road A.A. Co. Md.

18. Funeral director: Thomas W. Singleton
Address: New Burnie Md

19. Jan 3 1946 (Date rec'd by registrar) M. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 2 1946 at about 1 A M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination 19
~~and that I last saw him alive on~~ Jany. 2 1946

Immediate cause of death: Acute Dilatation of Heart — Duration: Sudden
Due to: Chronic Myocarditis — Duration: unknown
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 1/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00138

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-C

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Regional Hospital, Ft. George G. Meade, Md.

How long in hospital or institution? 4 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Italy County:

City or town: Cassamica Via D. Alighieri 35, Chee
(If ontside city or town limits, write RURAL and give nearest town)

Street No.: Berganco, Italy
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: AGOSTINO MAFFEIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	–

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): – 1913

8. AGE: Years	Months	Days	If less than one day
32	–	–	hrs. min.

9. Birthplace: Italy
(Town, connty, and stste)

10. Usual occupation: –

11. Industry or business: –

FATHER
12. Name: –
13. Birthplace: –

MOTHER
14. Maiden name: –
15. Birthplace: –

16. Informant: Medical chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereot 1/15/46 (month) (day) (year)

Cemetery or crematory: Post Cemetery.

Location: Fort Geo. G. Meade, Md.

18. Funeral director: Howard M. Blight Jr.

Address: 4914 Belair Road.

19. 13 January 1946 (Date rec'd by registrar) Frank J. Tollison (Registrar)
FRANK J. TOLLISON, CAPT., MC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 JANUARY, 1946, at 1600 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... im ...alive on ..... 19.....

Immediate cause of death: Atelectasis	DURATION
Due to: metastatic carcinoma, left testis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the canse to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (Conuty) (State)

Injured at home, tarm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. H. Kennedy, Capt. MC
M. D. or other

Address: Regional Hosp. Ft. Meade Date signed: 10 Jan 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00139

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 55 Calvert St Annapolis Md.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 55 Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Edward Mason

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Widower

6.(b) Name of husband or wife: Alice Mason
6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): February 1889

8. AGE: Years	Months	Days	If less than one day
56	11		....hrs. ....min.

9. Birthplace: LaPlatta Charles Co. Md.
(Town, county, and state)
10. Usual occupation: general utility
11. Industry or business: None

FATHER
12. Name: Madison Mason
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: Alice Vond
15. Birthplace: Charles Co. Md.

16. Informant: Mrs Elvelyn Mason Dennis
Address: 55 Calvert St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/19/46 (month) (day) (year)
Cemetery or crematory: Sacred Heart Cemetery
Location: LaPlatta Charles Co. Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 18 1946 (Date rec'd by registrar) Registrar: W. O'Donnell
13.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1946, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Jan 16 1946
and that I last saw him alive on Jan 15 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Amputated L. leg - auto injury	1943

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Kavanaugh, Md. M. D. or other
Address: 3 E Southgate Ave Date signed: 1/18/46

Evidence for change in age is shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH FILM No. I 04 MAY 28 1946 (83-a)

County A. A. Registration Dist. No. 20

Village or City Friendship No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Basil Maynard If U. S. Veteran, specify WAR

(a) Residence: No. Friendship St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	C	

5a. If married, widowed, or divorcad HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Aug 15 - 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1775 54			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Oata deceased last worked at this occupation (month and year)

11. Total tima (years) spent in this occupation

12. BIRTHPLACE (city or town) a. (State or country) a. a. Co Md

FATHER

13. NAME Eli Maynard

14. BIRTHPLACE (city or town) Dahlgreen (State or country) Calvert Co.

MOTHER

15. MAIDEN NAME Georgana Maynard

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT John Maynard (Address) Friendship

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Friendship Oate 2-3- 19 46

19. UNOERTAKER D. E. Haught & Son (Address) Galwell Md

20. FILEO 2/2 19 46 W. P. Clayton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 31 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceasad from 10 Jan, 1946, to 31 Jan, 1946

I last saw him alive on 30 Jan, 1946 death is said to have occurred on tha date stated abova, at 9 A. m.

The PRINCIPAL CAUSE OF DEATH and related causas of importance were as follows:

	Date of onset
Cerebral Hemorrhage.	

Other Contributory Causes of importance:

hypertension	

Name of operation Oate of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Date of injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. D.

(Address) Hancock Town Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00141

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Naval Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 909 Munroe St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Meiner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Meiner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2d, 1859

8. AGE: Years	Months	Days	If less than one day
86	9	19	hrs. min.

9. Birthplace: New York State (Town, county, and state)
10. Usual occupation: Water tender 1st/C-U.S.N. Ret.
11. Industry or business

FATHER
12. Name: Jalen Meiner
13. Birthplace: New York

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Frances Meiner
Address: Eastport - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany. 24, 1946 (month) (day) (year)
Cemetery or crematory: St. Annis Cemetery
Location: Annapolis, Md.

18. Funeral director: Jalen M. Taylor & Son
Address: Annapolis, Md.

19. Jan 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 January 1946 at 9:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19.46 to 21 January 19.46 and that I last saw h.i.m. alive on 21 January 19.46

Immediate cause of death	DURATION
Broncho Pneumonia	2 weeks
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: None performed. Date of op.
Autopsy results: None performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R A Barthel Lt (MC) USNR M. D. or other
Address: U.S. Naval Hosp. Annapolis Date signed: 21 Jan 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore (20-D)

00142

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 84 years
Hospital, Institution, or street address where death occurred:
34 Gotts Court
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Aru del CO.
City or town: Annapolis Md.
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 34 Gotts Ct.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: William Samuel Murdock

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Widower

6.(b) Name of husband or wife: ********
6.(c) If alive, give age: ******* years

7. Birth date of deceased (mo., day, yr.): January 3 1861

8. AGE: Years: 84 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Peter Murdock
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Harriet Anderson
15. Birthplace: Annapolis Md.

16. Informant: Mrs Ardenia Parker
Address: 60 Washington St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/46 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 14 19 46 (Date rec'd by registrar) Registrar

B.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-12-46 19..., at 3 35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10-46 19... to 1-12-46 19...
and that I last saw him alive on 1-11-46 19...

Immediate cause of death	DURATION
Cerebral Ischemia	
Gastro-enteritis, with diarrhoea and Emesis	
Due to: Emesis, dehydration	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M. D. or other
Address: 17 Carroll St. Date signed 1-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

00143

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a. a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Maryland County: a a

City or town: Tracy's Landing

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mammie Parks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
+	W	married

6.(b) Name of husband or wife: James T Parks

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): march 13 - 1884

8. AGE: Years	Months	Days	If less than one day
61	10	11	...hrs. ...min.

9. Birthplace: Va

(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER — 12. Name: alexander barnsell

13. Birthplace: Va

MOTHER — 14. Maiden name: Amanda Payne

15. Birthplace: Va

16. Informant: James T. Parks

Address: Tracy's Landing

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26/46 (month) (day) (year)

Cemetery or crematory: A Jones

Location: Tracy's Landing

18. Funeral director: B. I. Hopkins

Address: annapolis. Md

19. Jan 25 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1946, at 3.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22 1945, to January 24 1946

and that I last saw h... alive on January 24 1946

Immediate cause of death	DURATION
Cardiac failure	
Due to: Cerebral thrombosis	
Due to: Infection in left knee occurring after reduction of fracture - old left	
Other conditions: Hysterectomy - old left (Oct 22 '45)	

(Include pregnancy within 3 months of death)

Major findings of operation: fracture - intracapsular left hip 2nd operation = hysterectomy Date of op. 10/23/45 1/24/46

Autopsy results: none performed

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: predisposing

Accident, suicide, or homicide: Date of

Where did injury occur? Tracys Landing Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Fall Injured at work?

23. SIGNATURE: David B Baldwin MD

M. D. or other

Address: Date signed: 1/24/46

Evidence for change of age of deceased is shown on

06144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-C

CERTIFICATE OF DEATH

FILM No. 100 FEB 14 1946

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs.
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital
How long in hospital or institution? Since 1-21-46 TO 1-31-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 26 Johnson St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Corraine Sallman Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Married

6.(b) Name of husband or wife: James Richardson

7. Birth date of deceased (mo., day, yr.): 26 May 1923 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
22 ~~2-3~~	8	26	..... hrs. ..... min.

9. Birthplace: Red River, Dansville Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Nelson Sallman
13. Birthplace: Red River, Dansville

MOTHER
14. Maiden name: Lethen Jarvis
15. Birthplace: Baltimore, Md.

16. Informant: Esther Sallman
Address: 26 Johnson St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2 1946 (month) (day) (year)
Cemetery or crematory: Adams Chapel
Location: Lothian, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis Md.

19. Feb. 3, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1.31 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/21 1946 to 1/31 1946 and that I last saw h..e.r alive on 4 PM 1/31 1946

	DURATION
Immediate cause of death: Peritonitis	
Due to: Adenocarcinoma colon	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Large fungoid neoplasm involving Lower Colon Date of op. 1.25.46

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. R. Novak M.D. or other
Address: U.S. Naval Hospital Annapolis, Md. Date signed: 2-1-46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00145

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all from
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Daniel R. Rogers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1900

8. AGE:

Years	Months	Days	If less than one day
45	3	9	hrs. min.

9. Birthplace: Charles County Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Sanitary Commission A.A. County

FATHER
12. Name: Unknown
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Chas Co Md

16. Informant: Leo Williams Friend
Address: Glen Burnie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-18-46 (month) (day) (year)
Cemetery or crematory: St Thomas
Location: Bellaton Md

18. Funeral director: Hunt & Ryan
Address: Medley Md

19. 1-19 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 16, 19 46 at 8 45 A M

21. I CERTIFY that death occurred on the date above stated; ~~[illegible] from~~ Post-mortem Examination 19 ~~[illegible]~~ Jany 16 19 46

	DURATION
Immediate cause of death: Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Clotty M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 1/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00146

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Preston Seyler

3.(b) Social Security Number: 218-14-3033

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 65 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farming
FATHER 12. Name: not known
FATHER 13. Birthplace: " " "
MOTHER 14. Maiden name: not known
MOTHER 15. Birthplace: " " "
16. Informant: Police
Address: Ferndale
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Ritchie Highway
18. Funeral director: Martin J. Connor
Address: 4800 Ritchie Highway
19. Jan. 6 1946 (Date rec'd by registrar) Ida M. Whitmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1946, at about 1 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19
~~and that I last saw him alive on~~ January 3 1946

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Myocarditis	unknown
Due to: Arterio-Sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 1/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-4)

00147

FILM No. I 0 1 MAR 26 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 162 Green st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary E. Shelton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Shelton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1862

8. AGE: Years	Months	Days	If less than one day
83	5	30	..... hrs. ..... min.

9. Birthplace: Annapolis, A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Rosa Bailey
15. Birthplace: Germany

16. Informant: Col. Wm J. Jones U.S.A. Ret.
Address: 214 Pottawatomie St. Leavenworth Kan.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29, 1946 (month) (day) (year)
Cemetery or crematory: Naval Academy Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.

19. Jan. 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1946, at 2 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944, to Jan 26 1946
and that I last saw her alive on Jan 26 1946

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency	Recent
Due to: Arteriosclerosis	Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: George A. Beard M. D. or other
Address: Annapolis Md. Date signed: 1-28-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore [illegible]

CERTIFICATE OF DEATH

00148

Reg. Dist. No. 23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County A. A.

City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
4 Second Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. County

City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Second Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ELVIRA M. SHIPLEY

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William R. Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	25	..... hrs. ..... min.

9. Birthplace: A. A Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Richard Shipley
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Agnew Quail
15. Birthplace: Balto., Md.

16. Informant: Miss Hazel Shipley
Address: 4 Second Ave., Ferndale

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/46 (month) (day) (year)

Cemetery or crematory: Friednship Cem.

Location: A. A. Co.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. Jan 9 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7, 1946, at 3:20A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1942, to Jan 7 1946 and that I last saw h.. alive on Jan 7 1946.

	DURATION
Immediate cause of death: Hemorrhage in the Brain	4 days
Due to: Chronic Interstitial Nephritis	3 years
Due to: Cardio-vascular Disease	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Bellenghia M.D.
M. D. or other

Address: Elkton, Md. Date signed Jan 8, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00149 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: A. A. Co. Md.
City or town: CLARKS STATION
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: CLARKS STATION
(If outside city or town limits, write RURAL and give nearest town)
Street No. OLD ANNAPOLIS & QUARTERFIELD Rds.
(If rural, give LOCATION)
2.(a) If veteran, name war: N

3.(a) FULL NAME: LOLA R. SHORT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: RUFUS IRVIN SHORT
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 17, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	3	hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business: OWN HOME
FATHER 12. Name: JOSEPH F. CLARK
13. Birthplace: Md.
MOTHER 14. Maiden name: MARGARET PUMPHREY
15. Birthplace: Md.
16. Informant: RUFUS I. SHORT
Address: CLARKS STATION
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JAN. 23 1946 (month) (day) (year)
Cemetery or crematory: LOUDON PARK
Location: BALTIMORE, Md.
18. Funeral director: WILLIAM COOK INC.
Address: 1217 ST PAUL ST
19. 1-22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 20 1946, at 5 50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/17/46 1946 to JAN 20th 1946.
and that I last saw h... alive on 1/19/46. 1946

Immediate cause of death	DURATION
HYPOSTATIC PNEUMONIA	5 dys.
Due to: CHRONIC ENDOCARDITIS.	UNKNOWN
CORONARY HEART DISEASE	
Due to:	
Other conditions: ARTERIO-SCLEROSIS	UNKNOWN
CARDIAC ASTHMA	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Glen Burnie Md. Date signed 1/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00156

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Powhatan Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.Co.

City or town: Powhatan Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John E. Shuckart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Barbara Hulka Shuckart

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 7, 1876

8. AGE: Years	Months	Days	If less than one day
69			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Baltimore and Ohio R.R.

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Barbara Shuckart
Address: Powhatan Beach, A.A.Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/46 (month) (day) (year)

Cemetery or crematory: Schwartz Cemetery

Location: O'Donnell St

18. Funeral director: John F. Denny, Inc.

Address: 715 Light St.

19. 1-17 '46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1942 to Jan 14 1946 and that I last saw h alive on Jan 14th 1946

Immediate cause of death	DURATION
Pulmonary Edema	few days
Due to: Chronic Endocarditis	unknown
Due to: Bronchial Asthma	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John C. Alexander M. D. or other

Address: Glen Burnie Date signed: 1/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

00151

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 5 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 10 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: STANLEY - ALBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): March 12, 1910 (?)

8. AGE: Years	Months	Days	If less than one day
35 (?)	10	16	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: -----

FATHER — 12. Name: Douglas Stanley
FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Gertie Bowers
MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 2/6 46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt.
Address:

19. (Date rec'd by registrar) Feb 6 1946 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1946 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1945 to Jan. 28 1946
and that I last saw h. im alive on January 28 1946

Immediate cause of death	DURATION
Epilepsy	Known to us since 3/23/45
Due to: ------	
Due to: ------	
Other conditions: Mental Deficiency	Known to us since 3/23/45

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: -----
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? ------

23. SIGNATURE: Chas. L. Bruford M. D. or other
Address: Crownsville, Maryland Date signed: 1/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

06152

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
147 Gloucester St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 Gloucester St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Harry Thomas

3.(b) Social Security Number: 214-05-0260

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): August 28th, 1887

8. AGE: Years 59 | Months 5 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Annapolis, A. A. Co. Md. (town, county, and state)

10. Usual occupation: Caretaker at

11. Industry or business: Taylor Funeral Chapel

FATHER
12. Name: James H. Thomas
13. Birthplace: A. A. Co Md.

MOTHER
14. Maiden name: Laura Virginia Clow
15. Birthplace: A. A. Co Md.

16. Informant: Mrs. David Carroll
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby. 2, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.

19. Feb. 1st, 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1946, at 5 9 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1940, to Jan 31 1946
and that I last saw h.. alive on Jan 30 1946

Immediate cause of death	DURATION
Coronary Thrombosis	acute
Due to Arterial Sclerosis	chronic
Due to	
Other conditions Chr. Interstitial nephritis	chronic

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. C. Boyd M. D. or other
Address: Annapolis Md Date signed 2-1-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. I 0 0 JAN 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06153

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs, 7 mo, 29 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 7 yrs, 7 mo, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. ----------
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3.(a) FULL NAME: VICTOR- SABRE

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Eddie Victor
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): ------- 1898

8. AGE: Years	Months	Days	If less than one day
47 73	---	---	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Washing
11. Industry or business: -------

FATHER
12. Name: ----------
13. Birthplace: ----------

MOTHER
14. Maiden name: Frances Armstrong
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal? Where?) Date thereof: January 20, 1946 (Month, day, year)
Cemetery or crematory: Halls Hill Cemetery
Location: Pocomoke, Maryland

18. Funeral director: Dennis and Watson
Address: Pocomoke, Maryland

19. Jan. 17 1946 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1946, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1938, to January 17 1946 and that I last saw her alive on January 17 1946

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since May 19, 1938
Arteriosclerosis	
Due to	
Due to	
Other conditions: Senile Psychosis- Depressed Type	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op. -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -------
Means of injury ----- Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed 1/17/46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

00154

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 years
Hospital, institution, or street address where death occurred:
8 Monument St Annapolis Md.
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Monument St. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Walker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife: **********
6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years	Months	Days	If less than one day
63			....hrs. ....min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None

FATHER
12. Name: George Walker
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Lettie Green
15. Birthplace: Annapolis Md.

16. Informant: Mrs Elizabeth Brown
Address: 7 W 107th St. New York 23 N. Y.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/15/46 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery, nr Sage Bottom
Location: Smithville, Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11. 1946 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated, ~~that I attended deceased from~~ Post mortem Examination Jan 11 1946 ~~and that I last saw h... alive on~~

	DURATION
Immediate cause of death: Cerebral Hemorrhage	sudden
Due to: General arterio-sclerosis	contracted
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 1/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00155

CERTIFICATE OF DEATH

★ Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Sudley, West River P.O. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: [illegible]
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Thomas Oden Walker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes E. Walker
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Oct 28 1873

8. AGE:	Years	Months	Days	If less than one day
	72			...hrs. ...min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business
FATHER 12. Name: Columbus Walker.
13. Birthplace: Md.
MOTHER 14. Maiden name: Rachael Dunigan.
15. Birthplace: Md.
16. Informant: Agnes E. Walker
Address: Sudley
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 6, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Harmony Ann.
Location: Mt. Harmony
18. Funeral director: C. A. Stadtler Son
Address: Baltimore Md.
19. 1/6 1946 W. H. Clayton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 1946, at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1945, to Jan 4 1946
and that I last saw him alive on Jan 3, 1946
Immediate cause of death: acute myocardial failure
Due to: hypostatic pneumonia
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson M.D.
M. D. or other
Address: Cattail Md. Date signed: 1/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

01082

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 8 days

Hospital, Institution, or street address where death occurred:

District Training School

How long in hospital or institution? 18 yrs., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Laurel-Fort Meade Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Ward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 1894

8. AGE: Years	Months	Days	If less than one day
51 yrs	2	8	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business:

FATHER

12. Name: Joseph Ward

13. Birthplace: Ireland

MOTHER

14. Maiden name: Sophia Ward

15. Birthplace: Philadelphia, Pa.

16. Informant: D.T.S. Records

Address: District Training School, Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 - 46 (month) (day) (year)

Cemetery or crematory: Dist Tr School Cemetery

Location: near Laurel Md

18. Funeral director: James Lenvald M D.

Address: Laurel Md

19. Jan 23 1946 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1946 at 1105 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1944, to Jan. 20, 1946

and that I last saw him alive on Jan. 20 1946

	DURATION
Immediate cause of death: acute Bulbar Palsy	1 day
Due to: Organic disease C.N.S. athetoid State	Life
Due to: mental Deficiency	
Other conditions: Imbecility	Life

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James Lenvald M.D. M. D. or other

Address: District Ts School Laurel. Md Date signed 1/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00156 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A A Co (North Linthicum)

City or town Old Annapolis Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A A Co

City or town North Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frederick J. Weber

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret Weber

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/16/ 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Battimore (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Jacob Weber

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Margaret Hendricks

MOTHER 15. Birthplace Ger.

16. Informant Margaret Weber

Address Old Annapolis & Camp Mead Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7th 1946 (month) (day) (year)

Cemetery or crematory Holy Cross Cem

Location A A Co.

18. Funeral director Leerich Funeral Home

Address 2008 Orleans St

19. 1/7/46 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1946 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to Jan. 4, 1946 and that I last saw him alive on Jan. 4th, 1946

Immediate cause of death	DURATION
Coronary Thrombosis	4 days
Due to Hypertensive cardio-vascular disease	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry Deilee M.D.

M. D. or other

Address 1226 Hanover St. Date signed 1/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00157

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: near Severna P/k, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: near Severna P/k. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westhaven on the Magothy
(If rural, give LOCATION)
2.(a) If veteran, name war: 2nd

3.(a) FULL NAME: Alice Maud West.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Married.

6.(b) Name of husband or wife: Harold E. West.
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): Jan 29, 1870

8. AGE: Years	Months	Days	If less than one day
75	11	23	hrs. — min.

9. Birthplace: Alexandria Virginia. (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: At home.

FATHER
12. Name: Benoni Wheat.
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Matilda Fetzhugh.
15. Birthplace: Virginia.

16. Informant: John West.
Address: Severna P.K. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24. 1946 (month) (day) (year)
Cemetery or crematory: West Burial Land, near Severn P.K. Md.
Location: on West Homes Farm, near Severn P.K. Md.

18. Funeral director: Wm. Treichler & Son.
Address: Baltimore, Md.

19. 1-24 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22 1946 at 10:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1946, to Jan 22 1946.
and that I last saw h. alive on Jan 21, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage.	12 hours
Due to Chronic Cardio - Vascular Disease	10 years.
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Billingsley M.D.
M. D. or other
Address: Glen Burnie. Md. Date signed: Jan 22 1946.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00158

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Thomas Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Katherine H. Wilson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1860

8. AGE:

Years	Months	Days	If less than one day
85	9	29	..... hrs. ..... min.

9. Birthplace Anne Arundel Co. Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name James S. Wilson
13. Birthplace A.A. Co., Md.
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Mrs. Arthur Marley
Address 106 Allendale St, Balto. Md
17. Burial Date thereof Jan 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Baltimore, Md.
18. Funeral director John H. Taylor Son
Address Annapolis, Md.
19. Jan. 16 1946 Wm. D. French
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1946, at 4.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to Jan 15 1946
and that I last saw h. him alive on Jan 14 1946

Immediate cause of death	DURATION
Coronary Thrombosis	4 days.
Due to Generalized arteriosclerosis	
Due to	
Other conditions Paralytic ileus (Include pregnancy within 3 months of death)	4 days

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klemans M.D.
M. D. or other
Address 31 Southgate Ave Date signed 1/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

90159

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs, 11 mos, 8 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 yrs, 11 mos, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME

WISHER - DOROTHY

3.(b) Social Security Number -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): March 5, 1934

8. AGE:	Years	Months	Days	If less than one day
	11	10	14	--- hrs. --- min.

9. Birthplace: Denton, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ----

FATHER
12. Name: James Wisher
13. Birthplace: unknown

MOTHER
14. Maiden name: Hilda Holmes
15. Birthplace: unknown

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) - Date thereof 1/28/46 (month) (day) (year)

Cemetery or Crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address

19. Jan 28 1946 (Date rec'd by registrar) E J Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1946, at 6:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11 1942, to January 19 1946 and that I last saw her alive on January 19 1946

Immediate cause of death	DURATION
Pneumonia, bronchial,	1 day
Due to: -------	
Due to: -------	
Other conditions: Idiot	Known to us since 2/11/42

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.: -------

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: ------

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ------- Injured at work? ------

23. SIGNATURE: Herbert V. Hinkle M. D. or other

Address: Crownsville, Maryland Date signed: 1/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 00160 25

1. PLACE OF DEATH:

County A A County Zone 25

City or town 5350 Patrick Henry Drive

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A. Co.

City or town ~~Baltimore~~

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5350 Patrick Henry Drive

(If rural, give LOCATION) Zone 25

2.(a) If veteran, name war

3.(a) FULL NAME Nettie C. Woolwine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or ~~wife~~ Burr Woolwine

Sept 22 - 1879 6.(c) If alive, give age ~~no~~ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
67	—	—	...hrs. ...min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name John Hughes

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden name M. Hoochlin

MOTHER 15. Birthplace West Virginia

16. Informant Mrs. Hazel Rattle

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1946 (month) (day) (year)

Cemetery or crematory Maplewood Cemetery

Location Elkins West Virginia

18. Funeral director Milton Schilling

Address 3914 S. Hanover St - (25)

19. Jan 2 1946 (Date rec'd by registrar) John M. Whitman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1946 at 11. AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/30 1945 to 1/1 1945 and that I last saw h~~er~~ alive on 1/31/45 1945

Immediate cause of death	DURATION
Heart failure due	
Hypertension	
Due to Cardiovascular	
disease	
Due to	
Other conditions Secondary anemia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M.D. M. D. or other

Address 203 Pulaski Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

00161

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo. 27 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6 mo. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pennsylvania Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3.(a) FULL NAME: WORKMAN - JOHN

3.(b) Social Security Number: 215-09-3365A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	Widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): ----------

8. AGE:	Years	Months	Days	If less than one day
	68	---	---	----- hrs. ----- min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: La boree

11. Industry or business: ----------

FATHER
12. Name: Mayor Workman
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Forbley ?
15. Birthplace: South Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20-46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address

19. Jan 25 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1946 at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1945 to January 17 1946 and that I last saw him alive on January 17 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 6/22/45
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: -------

------- Date of op.

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) -------

Means of injury ------- Injured at work?

23. SIGNATURE: Walter L. Winstead M. D. or other

Address: Crownsville, Maryland Date signed: 1/18/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING